STATE OF NEW HAMPSHIRE
BOARD OF PHARMACY
57 Regional Drive
Concord, NH 03301-8518
Tel. (603) 271-2350 Fax: (603) 271-2856
Internet: www.state.nh.us/pharmacy

Board Use Only (Do Not Write In This Box)

Check #:_____

Permit #:

APPLICATION FOR PERMIT TO CONDUCT A PHARMACY IN NEW HAMPSHIRE

(Please Use Typewriter Or Print Clearly In Ink)

Check Type of Application (and include applicable fee with application):

☐ New Pharmacy / Original Application ⇒ $ 500.00

☐ Change of Location ⇒ $ 250.00

☐ Change of Ownership ⇒ $ 250.00

Make checks payable to: *NH BOARD OF PHARMACY*

PHARMACY INFORMATION

Name Of Pharmacy		
Street Address Of Pharmacy		
City/Town	State **NH**	Zip Code
Telephone Number	Fax Number	E-Mail Address
DEA Number		Expiration Date

PHARMACIST-IN-CHARGE STATEMENT

I, _____, of _____
Designated Pharmacist — Home Address (Not P.O. Box)

_____ do hereby agree to serve as
City/Town — State — Zip Code

pharmacist-in-charge at a pharmacy known as _____.
Name & Address Of Pharmacy

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TYPE OF PHARMACY

This Application Is For A Permit To Conduct A: (Check One)

☐ Community Pharmacy ⇒ If Community Pharmacy, Licensing: ☐ *Entire Store Area* ☐ *Pharmacy Dept. Only*

☐ Hospital Pharmacy (For Profit) ☐ Hospital Pharmacy (Non-Profit)

☐ Home Infusion Pharmacy ☐ Other (Specify) _____

TYPE OF OWNERSHIP

(Check One)

☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ LLC

(Check One)

☐ For Profit ☐ Non-Profit

- If **non-profit organization**, and **IRS tax exempt**, attach a copy of the 501(c)(3) exemption approval issued by the U.S. Internal Revenue Service for each applicable entity.
- In the case of non-501(c)(3) organizations, attach a disclosure listing of **any** practitioner ownership which is not exempt as a "passive investment acquired at open market terms". (practitioner means any person lawfully entitled to prescribe medicine, or such person's spouse or dependent children).

If a **sole proprietorship**, list the name, official address, and occupation/business of owner:

_____

If a **partnership**, list the name, official address, and occupation/business of each partner and the percentage of ownership held by each partner:

_____

_____

_____

If any partner is a corporation, that partner shall **also** provide the information required of corporations below.

If a **corporation** (list the following):

Corporation name and date and state of incorporation:

_____

If applicable, date of filing with the State of New Hampshire as a foreign corporation:
(attach copy of authorization issued by the NH Secretary of State)

_____

Address of principal place of business:

Name, address, & telephone number of **agent of record**, in New Hampshire, for service of process:

List each type, or class, of voting stock and the number of shares authorized and outstanding for each class:

CORPORATE INFORMATION (CONTINUED)

- Provide as a supplement to this application, the name, address, corporate title, occupation and percentage of stock held for all corporate officers/directors, and of all holders of 5% or more of each class of voting stock.
- If a listed shareholder is itself a corporation, provide the same for each such corporation.
- If a listed shareholder is a partnership, provide the information required under the partnership section on page 2 for each such partnership.
- Provide as a supplement to this application, the disclosure of the corporate structure, including parent company or companies.

LEGAL PROCEEDINGS/ACTIONS

To your knowledge, have there been or are there now pending any indictments of any nature or any alleged violations of the law governing the practice of pharmacy, controlled substances, or other regulated drugs against the corporation, members of the corporation or partnership, or any of the individuals named in this application?

☐ Yes ☐ No (If yes, attach explanation)

To your knowledge, have any of the above individuals/entities been convicted of a local, state, or federal drug or pharmacy law?

☐ Yes ☐ No (If yes, attach explanation)

To your knowledge, have any of the above individuals/entities been convicted of a felony within the past 10 years?

☐ Yes ☐ No (If yes, attach explanation)

PHARMACY HOURS OF OPERATION

This pharmacy shall be open a total of _____ hours per week and available to provide professional services during the following time periods:

MON. _____ TUES. _____ WED. _____ THUR. _____ FRI. _____

SAT. _____ SUN. _____

PHARMACISTS TO BE EMPLOYED AT PHARMACY
(Including Owner/Manager, If A Licensed Pharmacist)

PHARMACIST NAME	NH LICENSE #	HOURS/WEEK

PHARMACY TECHNICIANS TO BE EMPLOYED AT PHARMACY

TECHNICIAN NAME	NH TECH REGISTRATION #

GENERAL PHARMACY INFORMATION/SPECIFICATIONS

What are the dimensions of that portion of the pharmacy devoted to the preparation of prescriptions? _____

Give a brief description of the pharmacy department. (Complete **only** if this is an original application for a new pharmacy **or** if changes have occurred to an existing pharmacy)

- **If for an original permit**, attach a schematic drawing to scale (¼" to 1 ft.) of this pharmacy. Plans for any substantial change at any time after an original permit is issued shall also be filed with the Board for approval **before** proceeding with such changes.

List persons (names & titles) who have security access to the pharmacy [according to Ph 303.02(m) and Ph 702.05(b)].

_____

_____

_____

TO BE COMPLETED BY ALL APPLICANTS FOR PHARMACIES NOT LICENSED BY THE OWNER

As chief administrative officer of _____ I certify that
Corporation/Partnership

_____ is designated by me as pharmacist-in-charge to operate
Pharmacist

this pharmacy in compliance with all federal, state, and local laws. I have read this application and all statements made are, to the best of my knowledge, true and correct.

_____ _____ _____
Signature Title Date

TO BE COMPLETED BY THE PHARMACIST-IN-CHARGE

PHARMACIST-IN-CHARGE AFFIDAVIT

I do solemnly swear and affirm that the answers and statements made in this application are true and correct to the best of my knowledge and belief, that this pharmacy has the required facilities and equipment and meets the conditions specified by the Board of Pharmacy, a copy of whose laws and rules I have read. I agree to replace promptly any item on the required equipment list which becomes lost, broken, or otherwise becomes unfit for use. I also agree to display the pharmacy permit in a conspicuous place in this pharmacy. I understand that this permit is issued to the pharmacy in the name of the corporation or the owner of the pharmacy. Upon my termination as pharmacist-in-charge this permit is not transferable; and upon any change in partnership composition; or upon the acquisition of the existing corporation by any person; or change in controlling interest in the corporation; or should the pharmacy be moved or closed or if the premises are damaged by fire or otherwise, this permit shall be immediately surrendered to the Board of Pharmacy.

I further agree to operate this pharmacy in accordance with all federal, state, and local pharmacy/drug laws and regulations.

_____ _____
Signature Date

REVISED 05/2008

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